COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
DEPARTMENT OF EMPLOYEE INSURANCE

2010 KEHP UPDATE FORM

To be completed by the Insurance Coordinator. Do NOT use this form to add or drop dependents.
This form is to be used to update information on health insurance, FSAs and HRAs.

GENERAL INFORMATION (*REQUIRED*)

SOCIAL SECURITY NUMBER	COMPANY NUMBER
NAME	COMPANY NAME

☐ **TERMINATION:** DATE EMPLOYMENT ENDS_____ DATE INSURANCE TERMINATES_____

Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military ☐ Other_____

☐ **REINSTATE:** DATE RETURNED TO WORK _____ DATE INSURANCE EFFECTIVE _____

Reason: ☐ Rehired ☐FMLA ☐ LWOP ☐ Military ☐ Other_____

☐ **TRANSFER** *or* ☐ **SUMMER TRANSFER**
- ***To be completed by the NEW company***
- ***No changes to current coverage are allowed on this form***

PRIOR COMPANY #:	NEW COMPANY #:
LAST DAY WORKED AT PRIOR COMPANY:	DATE HIRED AT NEW COMPANY:
COVERAGE END DATE FROM PRIOR COMPANY:	COVERAGE BEGIN DATE AT NEW COMPANY:

OTHER CHANGES OR CORRECTIONS FOR **MEMBER** ☐ **SPOUSE** ☐ **CHILD** ☐

NAME	NEW		
	PREVIOUS		
NEW ADDRESS (where mail received)	STREET ADDRESS:		
	CITY:	STATE:	ZIP CODE:
E-MAIL:			
SSN:	CORRECT:	INCORRECT:	
DATE OF BIRTH:	**OTHER:**		

I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.

EMPLOYEE SIGNATURE	DATE	COORDINATOR SIGNATURE	DATE

Insurance Coordinator: Mail this form to Dept. of Employee Insurance, 501 High St., 2nd Floor, Frankfort, KY 40601

Revised 11/19/2009